MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Work Out Work Hardening C/O Michael Anderson, RN P O Box 852312 Mesquite, Texas 75185-2312	MDR Tracking No.: M4-03-6692-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Fidelity & Guaranty Insurance Company P O Box 13367 Austin, Texas 78711-3367 Box 19	Date of Injury: Employer's Name: CNF Incorporated Insurance Carrier's No.: A264602931000010164

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/09/02	10/09/02	99499-RP	$50.00	$0.00
12/20/02	12/20/02	99203	$74.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

This letter is requesting your help in receiving full compensation for services provided to Mr… We have not received payment for the following services on 10/10/02."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not respond to the dispute. EOBs state, "G-Unbundling (charge included in another bill). F-Fee guideline MAR reduction."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The carrier denied service for CPT code 99499-RP as being global to another bill.
However, the services provided were by a Licensed Social Worker, based on progress notes for the date of service 10/09/02, who is part of the interdisciplinary team according to MFG (II) and (II)(E). These progress notes were not part of an entrance or exit/discharge criteria, but were done within the program itself.
Therefore, based on the information provided reimbursement is not recommended.

Per 1996 MFG E/M descriptor, CPT code 99203 is for the evaluation and management of a new patient. The notes indicate a functional assessment by an OTR/L. The notes do not indicate this is a new patient and reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled reimbursement.

Ordered by:

	Michael Bucklin	02/18/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____